MONTANA BOARD OF NURSING
301 S PARK, 4TH FLOOR (Delivery)
P. O. Box 200513
Helena, Montana 59620-0513
(406) 841-2340 FAX (406) 841-2305
E-MAIL: dlibsdnur@mt.gov **WEBSITE**: www.nurse.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.
(Please allow 14 days for processing from the date that the Board has a complete routine application)

MEDICATION AIDS ARE NOT PERMITTED TO PERFORM ANY SERVICE OUTLINED BY ADMINISTRATIVE RULE 8.32.1414 WITHOUT AN ACTIVE MONTANA LICENSE

LICENSE REQUIREMENTS FOR MEDICATION AIDES

- Must have completed a Board approved Medication Aide training program
- Must pass the Board approved Medication Aide exam at 85% proficiency within 6 months of completing the training program. (Please refer to the Board Rule ARM 8.32.426 (2).
- Must be at least 18 years of age
- Must be a high school graduate

FEES

$ 25.00 Medication Aide Application Fee

******Make check or money order payable to the Montana Board of Nursing**

DOCUMENTS

The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application.

Certificate of Completion from a Board approved Medication Aide Program
Current verification for all states which you hold/have held a professional license/certificate
Proof of age, such as, birth certificate, drivers license etc.
Copy of high school diploma

APPLICATION PROCEDURES

- When the application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- If the application is considered an irregular application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Irregular applications may take up to 120 days to process.
- All verifications of licensure must be sent directly from each state board in which the applicant is currently or has ever been licensed. Please make copies of the attached verification request form as needed. Some states may charge a fee for verifications. Contact each state board prior to sending the request.

- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES

- Once a routine application is complete, the application takes up to 14 days to process from the time it is received in the Board office.
- The applicant will be notified in writing of any deficient or missing items from the application file.
- Once a routine application is processed and approved a permanent license will be issued.

For information with regard to the processing of this application or other concerns please contact the Board of Nursing staff at (406) 841-2340 or email us at dlibsdnur.mt.gov .

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR THE PRACTICE OF MEDICATION AIDES ON OUR WEBSITE: www.nurse.mt.gov

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Application for Licensure as: MEDICATION AIDE

Allow 14 days from the date the Board has a complete routine application file for licensure.

1. FULL NAME: _____
   Last First Middle
2. OTHER NAME(S) KNOWN BY _____
3. BUSINESS NAME _____
4. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip
5. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS _____
6. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax
7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____
8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE
   City/State
9. LICENSE NAME _____
   (State your name as it should appear on the license if granted.)
10. PROFESSIONAL EDUCATION:

Name of Board Approved School	City	Dates Attended	Certificate Received
			☐ Yes ☐No
			☐ Yes ☐No

11. Do you intend to practice in Montana? ☐ Yes ☐ No
12. Have you ever previously applied for a license to practice in Montana: If yes, give type of license applied for, date and results. ☐ Yes ☐ No

13. Have you ever withdrawn an application for medication aide licensure? If yes, please give the state and reasons for the withdrawal. _____ ☐ Yes ☐ No

14. Have you ever been denied licensure or the opportunity to take this profession's licensing examination in any state? If yes, attach an official document ☐ Yes ☐ No

15. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory.

State	License #	Issue Date	Expiration Date	License Method	Requested State Verification
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No
				☐ Exam ☐ Endorse ☐ Other	☐ Yes ☐ No

16. Have you ever been certified by another government agency? ☐ Yes ☐ No

Certifying Agency	Certification	Date Awarded, Re-certified

Have you ever been denied a certification or failed to pass a certification examination or portion thereof? ☐ Yes ☐No

By whom?_____

Reason for denial?_____

17. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements. ☐ Yes ☐ No

18. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

19. Has a complaint ever been made against you alleging unethical behavior, standard of care issues or unprofessional conduct? If yes, attach a detailed explanation. ☐ Yes ☐ No

20. Have you voluntarily or involuntarily surrendered any hospital privileges, health maintenance organization participation, Medicare/Medicaid privileges, or other privileges during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

21. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations. ☐ Yes ☐ No

22. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? If yes, attach a detailed explanation. ☐ Yes ☐ No

23. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. ☐ Yes ☐ No

24. Do you have criminal charges pending or have ever plead guilty, forfeited bond, or been convicted of a crime (including plea of no contest or deferred prosecution) whether or not an appeal is pending? You may omit: (1) payment of traffic misdemeanor fines and (2) charges or convictions prior to your 16th birthday. If yes, please attach a detailed explanation. ☐ Yes ☐ No

25. Have you any physical or mental condition which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. ☐ Yes ☐ No

26. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ Yes ☐ No

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Nursing.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____
Legal Signature of Applicant Date

Subscribed and sworn to before me this _____ day of _____, _____at

_____.
City/State

_____
Signature of Notary Public

SEAL

_____
Notary Public Printed Name

_____
For the State of

My commission expires _____, _____.

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A MEDICATION AIDE. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a license to practice as a Medication Aide in the State of Montana. The Board of Nursing requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF NURSING, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

_____ Name: _____
(Signature) (Please print)

Address: _____

_____

My License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF NURSING

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

_____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

BOARD SEAL

Signed: _____
Title: _____
State Board: _____ Date: _____